

**Health Form Example** (formatting may be different, but questions are the same)

Health Form Front

Leader's Copy

In the effort to accommodate the individual needs of each of our Ambassadors, we ask that the student's parent or guardian complete the following health form. All information is confidential and may only be released to People to People program staff. In the event of an emergency, information provided can be given to the appropriate medical authority.

Today's Date

**Please submit this to the leader at your first orientation**

Delegate's Name

**meeting**

Delegate's ID Number

Street address

City

State

Zip

Phone

 ( )

Date of Birth

Gender:

Male ☐ Female ☐**Does your child currently have any of the following conditions or symptoms?**

An acute medical issue	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Severe visual impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Seizures or Epilepsy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(not corrected by glasses/contacts)		
Mobility limitations	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Severe hearing impairment	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Mental health issues	Yes <input type="checkbox"/>	No <input type="checkbox"/>	(not corrected by hearing aids/implants)		
( i.e. depression, mood disorders, anxiety, eating disorders)					

If you answered "yes" to any of the above items, please explain below:

Condition	Detailed Description
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**MEDICATIONS:****NONE:** ☐

Describe in detail any medications or treatment your child will be using while on the program:

**Medication:****Reason:****Medication:****Reason:****ALLERGIES****NONE:** ☐

Allergy	Reaction	Medication Required	Life Threatening?
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

For allergic emergencies, my child carries auto-injectable epinephrine (i.e. Epipen) Yes ☐ No ☐**DIETARY REQUIREMENTS** We cannot guarantee certain meal requests**NONE:** ☐
  


form continues on opposite side



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Additional description of health conditions, if necessary:

Physician's name

Physician's phone number

We require all delegates participating in the People to People Ambassador Programs to care for their recurring medical treatments without supervision. All medications, injections, or other treatments must be monitored and administered by the individual. Please understand we cannot control the contents of food products during travel. Should your child have dietary allergies, he/she is ultimately responsible for inspecting all food for ingredients related to the allergy.

Parent of Guardian: I hereby authorize and give full consent to program staff to enable prompt care and attention in case of illness or accident incurred by my son/daughter while he/she is participating in the People to People Ambassador Programs, in the event I cannot be contacted. I also hereby authorize the leader to incur the necessary expenses, and I agree to pay the same if in excess of the amount provided by any applicable insurance policy. I further acknowledge and agree that all of the above requested information is necessary to ensure safe participation of my child/children in the program and activities provided by People to People.

Signature (parent/guardian):

Date:

Print name: